

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN5064ADA	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2010
NAME OF PROVIDER OR SUPPLIER BEYOND 585 SAGE STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 585 SAGE ST ELKO, NV 89801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	<p>Initial Comment</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your facility on 2/24/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is requesting licensure for five residential program beds for the treatment of abuse of alcohol and drugs. The census at the time of the survey was four. Four resident files and two employee files were reviewed.</p>	D 000		
D 106 SS=C	<p>NAC 449.123(2) Sanitary Requirements</p> <p>2. A facility which provides dietary services must have food service equipment of appropriate quality and type for the type of food service program used by the facility. The equipment must comply with all applicable provisions in chapter 446 of NAC.</p> <p>This Regulation is not met as evidenced by: Based on observation on 2/24/10, the facility was not using commercial grade kitchen appliances per NAC chapter 446.</p> <p>Severity: 1 Scope: 3</p>	D 106		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE